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THE ASSESSMENT OF SELF-ESTEEM BEFORE AND AFTER A THERAPEUTIC MILIEU PROGRAMME

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ABSTRACT

The present quasi-experimental study was conducted in ward G22, a milieu therapy unit at Cape Town's Groote Schuur Hospital. It examines self-esteem of patients prior to and subsequent to completion of the therapeutic milieu programme, using a self-report questionnaire, the Rosenberg Self-Esteem Scale. This questionnaire was used to measure the level of self-esteem after completion of a 9-12 week stay in G22.

The questionnaire was administered to twenty-three successive patients admitted to the unit. Of these, one terminated prematurely by committing suicide, while the questionnaire was re-administered to the remaining twenty-two subjects in the final week of their treatment. Protocols were computer scored and quantitatively analysed using Wilcoxon Rank Sum and Signed Rank tests of significance. This analysis indicated that there was a general improvement in self-esteem of subjects after completion of the therapeutic milieu programme, while there was a significant improvement in self-esteem of older subjects when compared with the younger subjects. Other variables such as language, gender and length of stay did not significantly affect the results.

Possible reasons for this improvement are considered, among which is the need to take into account the treatment context when evaluating change. The study concludes that further research is necessary in G22 in order to assess treatment outcome studies, and also to assess whether change is maintained after discharge. It further recommends that additional research is necessary which pays attention to the role of the treatment context and the effectiveness of the treatment modalities utilised.

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CHAPTER ONE

INTRODUCTION

Rationale of the study

In 1995, the author was a member of the multi-disciplinary team of Ward G22, Groote Schuur Hospital, Observatory. G22 is a milieu therapy unit, an in-patient psychiatric therapeutic facility which is staffed by a multi-disciplinary team.

G22 admits patients in the DSM-IV (1994) categories of eating disorders, depression, anxiety and personality disorders. However, there have also been admissions of patients with post-traumatic stress disorder, pain disorder and dissociative disorders. This variability among diagnostic categories appears to be based upon the principle that patient heterogeneity is mutually benefiting for patients, and has a balancing effect on the patient complement (Jones & Rapoport, 1976). Patients range in age from 15 through 47 years and are admitted for a 9-12 week stay.

As a milieu therapy unit, G22 values the ethos of change as a discourse in the unit's therapeutic programme. The nature of this change and the effectiveness of the treatment in facilitating it are, however, not explicit. It is important to note that, for the purpose of this study, it was necessary to assume uniformity in the delivery of treatment and the therapeutic programme. This assumption is commonly made in therapy outcome research (Messer & Boals, 1981; Norman & Lowry, 1995). Although problematic, it allows for preliminary descriptions of psychotherapeutic change. The author was interested in assessing the level of self-esteem before and after completion of the 9-12 week programme.

The self concept forms an important part of the individual's personality, encompassing the way an individual sees himself, how he would like to see himself and how he shows himself

to others. It implies self-acceptance, self-respect and feelings of self-worth. A person with high self-esteem is fundamentally satisfied with the type of person he is, and conversely, a person with low self-esteem considers himself unworthy or inadequate as a person. Argyl (1941, in Rosenberg, 1965:54) viewed self-esteem problems as the heart of the neurotic process, while other studies (Rosenberg, 1965) correlated self-esteem with emotional disturbances, such as anxiety and depression. Self-esteem is, therefore, relevant in the development of emotional disturbance, while a high level of self-esteem is an important component of mental health. A high level of self-esteem serves an anxiety-buffering function. Thus, people with depression, anxiety and emotional disturbance will have low self-esteem, and interventions that increase self-esteem would also influence indicators of mental health, self-acceptance, self-respect and self-worth. It would indicate that one is able to master or cope with situations. After infancy, the self is the object that is most essential to one's adaptive success. Consequently, a positive attitude toward the self has the adaptive value of functioning to protect and foster this critical object (Greenwald, 1989:39).

Purpose of the study

This study aims to show that there is a correlation between self-esteem and emotional disturbance. This will be assessed by establishing patient self-esteem scores upon admission to ward G22 and upon discharge from the ward.

There have been numerous studies on self-esteem (Rosenberg, 1965; Bachman,1970; Beck,1967) but none within the context of a therapeutic milieu. This study will enable the team of G22 to assess and evaluate the programme, based on the level of improvement in the patients' self-esteem.

Outline of the study

This study explores the concept of self-esteem. the manifestation and changes in levels of self-esteem before and after a therapeutic intervention programme. In the second chapter contemporary literature on the nature of the self will be reviewed. This includes the definitions of self-esteem and theories of self-esteem. It traces the development of the self from the theories of Freud, Jung, Object Relations and Self Psychology. A brief explanation of the development of psychopathology within these theoretical frameworks is offered, with more emphasis on the theory of Self Psychology and the development of pathology within a Self Psychological context. The third chapter includes a review of the concept of the therapeutic milieu and its history. It includes a discussion of the rationale and structure of the therapeutic milieu and finally the therapeutic programme of ward G22.

The fourth chapter focuses on the methodology which includes the description of the empirical instrument used in the study. The Rosenberg Self-Esteem Scale was used in this study to measure the self-esteem of patients before and after treatment in the ward. There is a discussion of the sampling and data collection procedures. The fifth chapter includes the evaluation of results and discussion pertaining to the results found. The sixth chapter gives a summary of the conclusions reached in this study and makes recommendations with references to future research in this area.

CHAPTER TWO

SELF ESTEEM

INTRODUCTION

There are different conceptionalizations of self-esteem which will be examined in this chapter. The chapter addresses definitions of self-esteem, general theories of self-esteem. tracks the development of the self from the theories of Freud, Jung, Object Relations and Self Psychology, and briefly explains the development of psychopathology within these theoretical frameworks. For the purpose of this study however, the development of psychopathology will be discussed more fully within the framework of Self Psychological theory.

DEFINITIONS

Self-esteem constitutes self-evaluative judgements about one's overall worth as a person (Harter, 1989:45).

Rosenberg (1965:30) had a similar conceptionalization of self-esteem. He noted that self-esteem is a positive or negative attitude toward a particular object, namely, the self. High self-esteem expresses the feeling that one is "good enough". The individual feels that he is a person of worth, respects himself for what he is, recognises his limitations and expects to grow and improve. Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction and self-contempt. The individual lacks respect for the self he observes, the self picture is disagreeable and he wishes it were otherwise.

James (1950, in Harter, 1989:45-49) proposed that self-esteem is a function of both one's goals and one's achievements. It is not sufficient to aggregate one's self-evaluative judgements over every domain of one's life. Rather, one's global self-esteem is derived from one's successes in those domains where one aspired to succeed. Thus, if one judged that one was successful in these critical domains, a high level of self-esteem would ensue. Conversely, if one's pretensions vastly exceeded one's perceived level of success, the outcome would be low self-esteem. This relationship reflects the fact that a person with low self-worth cannot discount the importance of areas in which he is unsuccessful, whereas the person with high self-worth seems able to discount the importance of those domains in which he does not feel adequate. This discounting is a protective mechanism.

Block and Robbins (1993:911) view self-esteem as the extent to which one perceives oneself as relatively close to being the person that one wants to be, and/or as being relatively distant from being the kind of person one does not want to be, with respect to person-qualities one positively and negatively values. It is crucial to know the specific self-values, and their weighting on which an individual predicts self-worth (Mc Glashan & Miller, 1982:381).

Cooley (1922, in Harter 1989) believes that how we see ourselves is influenced by how we think others perceive us. His concept of a "looking glass self" (ibid:45) focusses on the relationship between images of the other, the imagination of others' images of us and the resulting self-evaluation, which refers to self-esteem.

THEORIES OF SELF-ESTEEM

There has been a long-standing interest in the individual's perception of himself, his situation, and how this influences behaviour. There are numerous theories about the development of the self ranging from Freud (1923, in Purkey, 1970), who focused on ego development and functioning. Mead (1934, in Harter, 1989) described the development of the self through transactions with the environment. Rogers (1947, in Purkey, 1970) focused on the importance of the self in human adjustment and suggested that the self is a central aspect of personality, which developed out of inter-personal relationships and that there was a need for positive regard from oneself and from others.

Jung (1969, in Corbet & Kugler, 1989:193) on the other hand, refers to the self as the regulating centre and the contents of the total personality, which motivates the personality toward the realization of its potential wholeness through the process of individuation.

Kohut (1977:102) states that we live in a world of self-objects, where the self object is an aspect of another person that serves to maintain our sense of self. The self is enriched and stabilised by the existence of others, who confirm our experience of our self. According to Kohut, "the self is a depth psychological concept that refers to the core of the personality, which is made up of various constituents that emerge into a coherent and enduring configuration during the interplay of inherited and environmental factors with the child's experience of its earliest self-objects" (Wolf, 1988:46-47).

Thus, the self can be viewed as a complex system of beliefs which the individual holds to be true about himself, and to which there is a constant striving to maintain, protect and enhance (Purkey, 1970:6).

The classical theories based development on the instincts and their vicissitudes, while more recent theories have increasingly seen personality development and its psychological manifestations as an interaction between the intrapsychic processes and cognitive and social processes, that is, the person as a whole. According to the classical theories, a person developed disorders when there was a disintegration of the "intact ego" (Sutherland, 1993:3). The more recent theorists, on the other hand, view psychological disorders as a manifestation of conflicts within the self or "identity" (ibid). Divisions within the self caused doubts about who one was and other disturbing existential phenomena.

Freud

Freud's (1955, in Sutherland, 1993) tripartite theory divided the mental apparatus into id, ego and superego. He focused on the self under the concept of ego development and functioning. Basically, the roots of motivation emerge from innate biological factors or instincts. Objects in the environment are used for drive discharge and either facilitate or frustrate this discharge. The superego and ego identification arise largely in response to such vicissitudes of drive discharge patterns. The effects of the environment are mediated secondarily through the superego and symptom formation is the result of repression of id impulses and ego defenses.

This view has been criticised by Sutherland (1993) as being atomistic and one which fails to do justice to the uniqueness of the self as a functioning whole. Nevertheless, the Freudian view provided a basis for understanding the psychology of the total person.

Jung

Jung's (1969, in Corbet & Kugler, 1989:193) concept of the self refers both to the regulating centre and the contents of the total personality. The self is the principle of structure and order within the psyche. It is also the totality of the conscious and unconscious psyche and its ultimate purpose is the integration of the personality. The psyche is a self- regulating system that attempts to maintain equilibrium, and its organising centre is the self.

Jung postulated that the child is born with a priori psychological matrix, out of which a personal consciousness emerges. This matrix is structured in characteristic ways (archetypes) that provide the potential for particular forms of experience, whose content is determined by the child's interaction with his specific environment. The unconscious contains "enzymes", which is given with the person's psychic anatomy. These "enzymes" digest the person's psychic experiences, which are taken in during the course of the person's life, and result in the subjective experience of personal identity.

Neumann (1954, in Corbet & Kugler, 1989) suggests that the mother "carries" the image of the child's self in unconscious projection, functioning "as" the baby's self. The infant experiences a self only in relation to the mother and her maternal capacity to mirror back the child's selfhood.

The child's development is dependent on both the mother's capacity to mirror, as well as the infant's innate capacity to meaningfully structure such an experience. The aspect of the child's psyche which structures this experience, the archetype of mother, represents the transpersonal quality of the self evoked in the human relationship (Jung, 1969 in Corbet & Kugler, 1989).

The above view is not supported by post-Jungian writers such as Fordham (1976) and Stern (1985), who stress the existence of a primary self in the child not dependent on the mother.

The Neo-Freudians

The Neo-Freudians, such as Melanie Klein, Fairbairn, Guntrip, Winnicott and Bowlby, modified the classical theory to give greater recognition to the influence of the needed external object and the surrounding culture. They developed an interpersonal psychology that stressed the direct influence of the environment, and noted that motivation is then shaped by the individual's relationship to objects during the formative years.

Melanie Klein (in Sutherland, 1993:4) pursued the implications of Freud's views on the importance of early development, in her work with young children. This radical development found that the rich content of children's inner worlds, a world populated by a range of figures in fantasised loving and hating relationships with each other and with the ego, were direct reflections of the instincts. These destructive impulses aroused intense anxieties, which Klein related to a dread of disintegration of the ego, or a loss of the cohering function of the internalised good mother. The ego splits into parts to lessen the inner terrors, and in this way dangerous content could be separated from the good content. The ego, according to Klein, initially splits the world into good and bad in order to make sense of it. Eventually it can integrate the part objects into a whole object. Unlike Freud, Klein assumed that the ego must be present from birth. She did not pursue the theoretical implications of her findings about the structuring of the self and how perceptions of the world and actions are influenced by the internalised objects.

Fairbairn (1944, in Wolf, 1988:198) modified the concept of ego, and described it as the "primary psychic self" in its original wholeness, a whole which differentiates into organised structural patterns under the impact of object relations after birth.

In Fairbairn's work on patients with schizoid personalities, psychopathology was seen as resulting from the failure of the mother to convey a feeling that she loved the infant and valued the infant as a person in his own right. He assumed an innate need in the infant that had to be met by the mother's emotional attitude toward her child. This need was a psychological, holistic need which arises in the self and can be described as a need for ongoing personal relationships. The infant was thus "personalised" by being spontaneously responded to as a person right from the start, first by the mother, and later by the father and other family members. It was this welcome into the world of social relations that laid the foundation for a sense of a security which is essential for the development of potential personal resources (Sutherland, 1993:8). Future personality structure was closely determined by the quality of these early experiences. Fairbairn (ibid) asserted that the crucial role attributed to the vicissitudes of instinctual energies and their satisfaction in the development of the personality, must be replaced by a theory of personality development which is the result of the person's experience with the environment, especially during the early stages of the life-cycle. He postulated a holistic ego at the centre, which was structured from experience. This notion employed the biological concept of holistic organising principles and emphasised that new levels of organisation invariably produce new properties that cannot be predicted from knowledge of the parts. While there are bodily and psychological transformations during the life cycle, the self as a whole is the constant thread that gives the feeling of being the same person.

Earlier, Erikson (1950, in Noam, 1989) and Lichtenstein (1977, in Sutherland, 1993) focused on the development of the self into an identity. According to Erikson (1950), an identity principle, a biological organising principle underlies these phases. The establishment and maintenance of identity is the principle that defines the concept of living and the survival of life and this takes priority over any other need. Spitz (in Sutherland, 1993:9) showed that the infant dies if no one gives enough love and care to set up a self, or organising principle, that wants to live.

Erikson's epigenetic phases evolved from the interplay of the self with its culture. Each new stage has a positive, strengthening outcome and a negative, weakening one, which arises out of the present crisis. It is not tied to libidinal zones, but to changes in the quality of the dominant self-feeling in its relationships with society.

Lichtenstein (in Sutherland, 1993:4) suggested that the infant self innately expects to find the constellation of a mother responding to it, and it responds at once to the mother as the object that completes its inner tension. Correspondingly, the mother begins to personalise the infant. It is the particular model that comes from her own needs, conscious and unconscious, that gives identity to the child. This initial shaping of the self operates permanently as an identity theme that persists throughout life, and is modified by subsequent experiences into many variations. Identity evolves into the structure through which the individual will perceive and interact with the world. The two basic features of the self are thus its autonomy and its concurrent membership in a

community.

Bowlby's (1973, in Josselson, 1989) work on attachment and autonomy show that self reliance is most evident in a context of a secure attachment. Attachment is important during the life-cycle and has important consequences for the formation of the self. The self is experienced as an object of others' attachment in that both our evaluation and our experience of ourselves is rooted in what we mean to others.

Mahler (1975) introduced the concept of the self as the whole person, which emerged as a coherent identity as a result of development through phrases of differentiation from a symbiotic matrix. The experiences of the infant with its mother during the earliest phases had a crucial effect on the future personality.

Self Psychology

Self psychology takes the position that attempts to avoid favouring either biological or environmental influences. The individual is born with certain potentials that are its biological heritage. It is in the interaction with the environment that some of these potentials will be evoked and brought into development, whereas others are left to atrophy.

It is focused on intrapsychic experiences of individuals, called the self-object experience, and simultaneously it attempts to be aware of environmental conditions that shape these self-object experience. It attempts with the help of developmental psychology, to delineate the ever-changing age-appropriate self-object needs of individuals.

Kohut (1977, in Wolf, 1988) developed a systematic psychoanalytic approach that was original, comprehensive and innovative, but based on the principles of psychoanalysis as formulated by Freud. It is an intrapsychic dynamic, not an interpersonal or object relations theory. He replaced the theory of instinctual drives and psychic energy with the concept of

phenomenology of conscious and unconscious subjective experiences as being the stimulus for organising the psychological structures, primarily the self. As noted in Wolf (1988) he differed from object relations theory in that it is not the reality of the relationship between self and object, but self conscious and unconscious experience of that relationship which determines the cohesion and vigour.

Kohut (in Sutherland, 1993:14) advocated the view of the self as the agent in the initiation and organisation of behaviour. According to him, the self at birth is largely a potential only, one that is required to merge with the mother to function in a progressively organised way and with a sense of constancy and spontaneity. The essential dynamic system is therefore, that of a self with a self-object or mother who is undifferentiated from the infant, and operates as the infant's self. As separation proceeds with development, the self becomes more autonomous and effective. However, a tie to others remains throughout life, even when the self fully recognises the separateness of others. The closeness of the self with the self-object is such that it is the subjectivity of the self-object to which the self mainly responds. With ordinary good parenting, the self works through two critical phases for its effective development. First the mother, as the main influence, has to respond empathically to the child's presence and achievements. From this experience, the infant gains a sense of omnipotence and grandiosity, that in due course, through interaction with others, is transformed into a reasonable sense of security, self-esteem and the achievement of abilities. As the earlier structuring of a grandiose self is taking place, a second structuring begins from the internalization of the admired parents as ideals that leads to the development of personal goals and values (Sutherland, 1993:14). At first the idealised parents exist as undifferentiated self-objects, and are then replaced by more separated ideal figures that function as ego ideal and superego.

Some of the criticisms of Kohut's theory have noted that it is an oversimplified view, in that distortions in the bipolar structuring of the self, around the early grandiose needs and the attachment to idealised objects, cannot explain all the major pathological developments of the self.

In conclusion, the self can be seen as a dynamic structure, in constant interaction with the social environment and its culture. When the latter no longer provides the affirmation the self requires, then the self tends to disintegrate, with widespread disturbances in the sense of well-being and hence various pathological reactions occur (Sutherland, 1993:20).

DEVELOPMENT OF PATHOLOGY FROM A SELF PSYCHOLOGY PERSPECTIVE

Throughout the course of life, the self is vulnerable to the absence, insufficiency or inappropriateness of self-object experiences. This vulnerability is greatest during the formative years, but injuries to the self can occur at any stage. At major developmental turning points or life-crises there appears to be a heightened vulnerability of the self to being injured by inappropriate self-object experiences. The newborn infant arrives physiologically pre-adapted for a specific physical environment. Similarly, psychological survival requires a specific psychological environment.

Wolf (1988) argues that the presence of responsive-empathic self-objects, which provide needed self-object experiences, give firmness and cohesion to the child's fragile self.
This would be the appropriate psychological environment.

A mother, in addressing and caring for and responding to her infant, creates for the child a self-object experience that has a structuring effect on the child's potential for self-organisation, so that the self is evoked and maintained. This emerging self, when it achieves a degree of cohesion, is experienced by the child as a sense of selfhood and is accompanied by self-esteem and the experience of well-being. Experiencing this self-evoking and self-maintaining self-object function is a need as long as the person lives. Thus, a healthy, mature self also needs a constant supply of self-object experiences. Symbolic self-object experiences replace the more concrete self-object experiences of infancy and childhood. The form of these will have undergone development, that is, adults read novels, listen to music, to meet current self-object needs.

Faulty interaction between the child and the care-givers, especially during the early years when the self first emerges, is experienced by the nascent self as a dangerous or even injurious self-object responsiveness (Wolf, 1988). The resulting traumatic self-object experiences lead to a diffusely damaged self, or to damage to a constituent of the self. Disorders of the self are by and large, but not exclusively, the consequence of miscarriages in the normal development of the self (ibid). The vulnerability of a weak self predisposes it to certain self-defeating defenses that lead to difficulties with potential sources of self-enhancing self-object experiences. Symptoms such as anxiety or excessive irritability warn of the impending threat to the self. These people suffer clusters of unpleasant symptoms in great discomfort or act out unacceptable behaviour.

HEALTH/PATHOLOGY CONTINUUM

An important issue in personality theory concerns its understanding of pathology. Millon (1981) noted a historical tendency for personality theories to focus either on normal or abnormal personality. Arguably, this has been at the expense of developing theory that provides an adequate explanation of both.

Current theories, in moving toward an integrated model which is able to account for the development of both normal and abnormal personality, appear to argue in favour of continuity between the two states and their developmental lines.

Millon states that "pathology results from the same forces as involved in the development of normal functioning. Important differences in character, timing and intensity of these influences will lead some individuals to acquire pathological traits and others to develop adaptive traits" (Millon, 1981:9). The individual is a constantly evolving being, who always has the potential for change.

THE GOAL OF TREATMENT

Relief of psychological pain is the most powerful incentive for seeking treatment. The ultimate aim of the therapeutic process should be to strengthen the self so that the person is willing and able to actively plunge into the rough and tumble of everyday life.

While no substitute experience can undo what happened in the past, or remove the emotional scars left behind, the goal of treatment should be to strengthen the self. This can occur in the

therapeutic situation through empathic resonance with the therapist, as the patient is allowed to reexperience the same old trauma, now in a changed context. The therapist is experienced as a self-object, while the changed experiential context also changes the meaning of the experience, so that there is a gradual loosening of the defensive armour acquired earlier in life to protect a modicum of self-structure and functioning. The self-structure is thus more accessible to changing experiences. As Wolf (1988) succinctly puts it, distorted aspects of the self's experience of itself and of others come into renewed contact with a different reality, which it may experience as benign, learn to understand and to which it may then gradually readapt itself.

Wolf (1988) further states that therapy should produce not only a person who possesses an intact sense of self, but also one who holds that self in substantial esteem. Related characteristics are a subjective sense of strength, courage and well-being, confidence and appropriate pride. It has been described as being friendly toward oneself, feeling convinced of one's likeableness, and experiencing a sense of competence that is consonant with actual ability. All these attributes are also reasonably independent of external sources of admiration. The individual is capable of experiencing and tolerating the affect of shame in appropriate situations without attenuation of core self-esteem (Mc Glasham & Miller, 1982:381).

CONCLUSION

It is the writer's view that self-esteem is an important indicator of mental health and that therapeutic intervention can impact substantially on the experience of the self in relation to others.

The next chapter will delineate treatment approaches used in the therapeutic milieu (ward G22) which can impact on self esteem.

CHAPTER THREE

THE THERAPEUTIC MILIEU

INTRODUCTION

Ward G22 is a therapeutic milieu situated in Groote Schuur Hospital. It offers a 9 to 12 week programme for the psychotherapeutic treatment of non-psychotic, non-organic psychological and\or psychiatric disorders. In this chapter the ward programme will be discussed in the context of therapeutic communities with in-patient psychotherapeutic approaches.

DEFINITION

Therapeutic communities developed in the mid-1940's and subsequently there has been extensive and diverse development of the model, nature and application, ranging from psychotherapy, through rehabilatation, to education (Wilson in Lindegger, 1979:19).

Milieu therapy has been defined as the purposeful use of people, resources, and events in the client's immediate environment, to promote optimal fuctioning in the activities of daily living, development or improvement of interpersonal skills, and the ability to manage outside the institutional setting (Garritson, 1992:743).

STRUCTURE OF THERAPEUTIC MILIEU

The therapeutic community is a structured environment with a specific philosophy of care. The focus is on health rather than illness. The patient is regarded as a responsible member of a social group and the treatment setting is viewed as a community of both patients and staff. All members interact democratically to achieve therapeutic outcomes, which include the development of insight into behaviour through feedback from the community, and the development of social and emotional skills.

Concomittant with the development of therapeutic communities, there has been rapid and extensive development of psychotherapeutic schools, approaches and techniques. These have been applied in individual, group and family contexts, as well as in specialised in-patient programmes (Yalom, 1983:105).

Dynamic psychotherapy aims to change not only the symptoms, but problems of recurrent maladaptive interpersonal relationships and of self-esteem, through resolution of intrapsychic conflict (Horowitz et al, 1986:583). There is general agreement within psychoanalysis that lasting changes after therapy in areas of interpersonal relations, working capacity and self-esteem may be achieved, through cognitive and emotional understanding of the dynamics of intra-psychic conflicts (McGlashan & Miller, 1982:165).

Wilson (1979:96) suggests that all therapeutic communities can be seen in terms of four essential dimensions of their operation, namely,

- structural component, which includes the social organisation, roles, relationships, hierarchies and communication channels.
- cultural component, which is concerned with the therapeutic atmosphere
- functional/therapeutic component, which refers to the aim of the community (psychotherapeutic) and the mechanisms through which they are achieved.
- systems component, which refers to the various group levels where the culture is established and through which the mechanisms of therapy are effected.

SETTING OF THE STUDY: WARD G22

G22 is a milieu therapy unit and is an inpatient psychiatric therapeutic facility staffed by a multidisciplinary team. A detailed review of milieu therapy literature is beyond the scope of this study, which does not seek to examine the effectiveness of milieu therapy or G22 as such, but rather to assess the level of self-esteem before admission to G22 and after completion of the therapeutic programme. As a milieu therapy unit, G22 values the ethos of change as a central discourse in the unit's therapeutic programme. The nature of this change and the effectiveness of the treatment in facilitating it are, however, not explicit.

Outcome studies that adequately examine in-patient treatments, are scarce. According to Ellsworth et al. (1979), in-patient outcome research has fallen into a number of different traps, which include:

- failing to control for the effects of in-patient input characteristics on the outcome being measured, and
- the use of poorly selected measures of programme outcome.

In terms of specific outcome-related factors, Jones and Rapaport (1976) indicate that treatment responses are complex in nature. They suggest that those patients who enter the unit with a greater degree of ego strength, and with fewer deficits in relation to social roles, show the best outcomes. Related to this, these patients generate more modest expectations amongst unit staff, and are rated as more improved (than other patients) at discharge.

Significant conclusions on the efficacy of therapeutic intervention emerge from Smith and Glass's (1977:752) meta-analysis of psychotherapy outcome studies. Most importantly, they concluded that the research demonstrated the benefits arising from counselling and psychotherapy, in that "the typical therapy client is better off than 75% of untreated individuals". Furthermore, the study concluded that the differences that emerge between various types of therapy are negligible, and that this held true for a broad comparison of behavioural and non-behavioural therapies.

Although these findings have been subject to critiques by, among others, Rachman and Wilson (1980), more recent studies (Shapiro & Shapiro, 1982) have confirmed Smith and Glass's (1977) conclusion of the general efficacy of therapy versus placebo treatments.

Furthermore, Shapiro and Shapiro (1982) have shown that the problem under treatment accounts for far more variance in treatment outcome than therapeutic modality.

If the difference in effectiveness of varying modalities is negligible (Smith & Glass, 1977), then it becomes possible to investigate change in milieu patients without necessarily attempting to specify the active ingredients of the milieu programme, such as how various components of the programme address symptom reduction or personality change. It also

becomes unnecessary to measure the efficacy of milieu treatment in comparison with any other sort of therapy.

For the purpose of this study it was then necessary to assume uniformity (for all patients) in the delivery of treatment and the therapeutic programme. This assumption is commonly made in therapy outcome research (Messer & Boals, 1981; Norman & Lowry, 1995). Although problematic, it allows for preliminary descriptions of psychotherapeutic change.

THE THERAPEUTIC PROGRAMME OF WARD G22

There is no uniformly applied therapeutic orientation in the unit, with therapists adopting a range of perspectives from broadly psychoanalytic through self psychological, eclectic, to more behavioural approaches. It is the author's view that the therapeutic programme is based on the theme of "therapeutic change through reality confrontation", a phrase coined by Jones and Rapoport (1976:210) in their research on milieu therapy units. Generally the staff at G22 appear to believe that their patients have personality difficulties due to early negative socio-environmental influences, which result in psychological difficulties in daily living during adulthood. In turn, development or ongoing personal learning may be effected by the utilization of therapeutic socio-environmental forces in the milieu's therapeutic programme. The aims are realised with the community and by the therapeutic community, through the implementation of a holistic multidimensional working model of the person. The treatment programme at G22 incorporates a multi-dimensional or eclectic frame for therapeutic interventions, which are outlined below. (Refer to Appendix I for information brochure.)

Group Therapy

This is considered by staff to be one of the most important aspects of the programme. These groups have the psychotherapeutic function of exploration, developing insight and working through, as well as facilitating the redecision process. They operate according to the principles of group psychotherapy (Yalom, 1983). In his work on in-patient group psychotherapy, Yalom refers to the social microcosm of the therapeutic community as the primary focus of therapy. He sees that the source and manifestation of psychopathology is primarily in interpersonal relationships. Through this medium each patient is provided with a specific interpersonal context in which to discover their interpersonal difficulties or distortions, and the way in which they contribute to the ongoing difficulties in living, which have brought them to treatment. It also offers a context for developing insight, and learning new and more adaptive interpersonal and social behaviour. Marmor (1980:415) also supports this view when he refers to the enormous power of the group as a modifying factor in human behaviour.

Groups are conducted three times weekly and all patients enter group within one or two weeks of their admission. Groups have two facilitators drawn randomly from a pool which includes most of the personnel (nurses, occupational therapist, registrar, psychologist, intern psychologist and social worker). Groups are generally supervised by the psychologist or social worker with input from other team members as well. Each pair of facilitators performs a six week block of therapy, with a two week overlap in order to gradually change facilitation. Groups are open, with patients constantly entering and leaving them as they are admitted to and discharged from the unit. The number of groups being conducted depends on the number of patients in the unit at any one time. There are usually two groups running concurrently.

The orientation of this group therapy is eclectic, and depends entirely on the facilitators involved. Styles range from very directive to non-directive, and all staff have various levels and types of training. Mostly, they subscribe to Yalom's (1983) inpatient group therapy approach.

Individual Therapy

All patients are assigned an individual therapist on admission to the ward. In the first two weeks after admission, the therapist is responsible for taking the history of the patient, for making a working diagnosis, and for therapeutic management recommendations (in consultation with the team). Thereafter, the therapist conducts weekly therapy with the patient. Therapy is performed by intern-psychologists, the registrar and the social worker, and rarely the psychologist. Intern psychologists are supervised by the psychologist, while the registrar and social worker are supervised by the consultant psychiatrist. Once again, the therapeutic modality depends on the therapist involved, and to some extent the supervisor's style. It could be stated that the therapy was brief dynamic therapy when one considers that it comprised of twelve weekly sessions.

Brief dynamic therapy refers to therapy "in which the time allotted to treatment is rationed" (Budman & Gurman, 1983:277). The time limit distinguishes it from long-term therapy. According to Becker (1988:5), brief dynamic therapy refers to brief therapy, in which consideration is given to the intra-psychic processes and psychogenetic aspects of the client's condition. It also includes working in such a way so as to promote insight into conflict and disturbed functioning. It incorporates various techniques, including interpretation, in order to promote client change.

Family Therapy

Most patients receive at least some family therapy during their stay. Family therapists are assigned during the ward round where the patient is "presented". This includes a full history-taking and diagnosis according to the DSM-IV (Diagnostic and Statistical Manual of the American Psychiatric Association), as well as the corresponding diagnosis according to the ICD 10 (International Classification of Disease). A psychodynamic formulation is done in order to discuss the therapeutic goals and management. This takes the form of a team discussion with input from all team members. It is also at this time that a decision is made whether family or couple therapy should be the focus of treatment and whether the patient needs medication. Thus there is a focus on the whole person and his potential resources. There is a focus on development rather than pathology.

Family sessions are usually done on a weekly basis, but there are occasions when families have come from afar, and the sessions are done on a daily basis for three or four days.
Upon discharge the family is referred for further therapy in the community.

Family therapists are drawn from the same professional pool of staff as for individual therapy and rarely from the nursing staff, that is, social worker, intern-psychologists and registrar. Here too, family therapy intervention styles are eclectic and decided by the orientation of the therapists involved. Most of the staff have been trained according to the Mc Master model of family therapy, while the social worker has more extensive training, including the Milan model of family therapy and Structural family therapy (Barker, 1992). The social worker is thus responsible for the supervision of family therapy.

Other Therapeutic Activities

These include weekly "evocative groups" co-facilitated by the psychology interns, registrar, occupational therapist, nursing staff and social worker. During these cathartic sessions, patients' emotions around a range of issues are evoked using various techniques, such as guided imagery, drawing, psychodrama or fantasy. These activities provide an opportunity to explore psychodynamic issues, develop insight and work through issues from the past. This takes the form of a group discussion where there are two facilitators. Group members assist in confrontation and provide support for each other.

Life-skills and anxiety management groups are facilitated by the occupational therapist and nursing staff. These include role-plays, assertiveness training and guided relaxation exercises. The cognitive level is concerned with the set of beliefs, values and attitudes of the individual. Life-skills and cognitive groups are concerned with the faulty or illogical assumptions of each person, and the effects of these on the behaviour and relationships of the person and their difficulties in daily living. Ongoing community-based feedback provides indirect sources of information for individuals about their faulty beliefs and assumptions.

Cognitive identity groups for patients with eating disorders are held specifically in terms of the specific problem focus and provide problem-specific support and learning (Lieberman, 1972).

There is also a focus on the bodily attitude of the individual and to the pattern of muscoskeletal tension which the person uses as a basis of defense in the world (Lowen, 1977). Attention to the physical dimension presumes that the body is used in a particular way in interpersonal interaction, which both reflects and reinforces the personal and interpersonal

difficulties of the individual. The body is important because of its role in emotional expression and difficulties, and can be seen as a medium for exploring the potential and limitations of the individual. Tensions are seen as defenses against basic feeling and the relationship of the physical to the psychological are brought to awareness, so that the patients can expand the way they utilise their bodily resources.

Patients are also involved in weekly group craft sessions, as well as individual craft sessions.

Twice weekly "community" sessions are held in which all patients and most staff participate. This social level is one of a variety of ways in which the community can provide feedback to the individual about his behaviour (Jones, in Lindegger, 1979:8). The purpose of these sessions are to explore any issues (usually conflict related) that may have arisen amongst patients or between staff and patients. This is also the forum where, two weeks after their admission, patients are asked to formulate their treatment goals and contract with the community. They are given feedback by the staff and fellow patients. On reaching the midpoint of their stay, patients are required to assess their progress, and once again are given feedback by fellow patients and staff. Just prior to discharge, patients evaluate what they have achieved during their stay, relative to their treatment goals and are again given final feedback. This is similar to Jones' (ibid) open case discussion, where patients receive intensive feedback.

Other ward activities include a daily "feel wall", an early morning activity run by the nursing staff, during which patients are required to indicate their mood states. This activity aims to facilitate a broader range of emotional response and experience, in order to improve the adaptive capacity of the individual, as well as to improve emotional awareness.

Patient administration groups consisting exclusively of in-patients, occur weekly. This is the primary channel for implementing and maintaining the essential democratisation of the community. It provides a context for patients to support, confront and monitor each other, while dealing with the daily domestic issues and practical arrangements of the community. It also functions to facilitate each individual's responsible participation in the community and to develop the capacity for altruism (Yalom, 1983).

Physical catharsis also occurs through the weekly sport sessions.

Finally, patients are also taken on a monthly outing to various cultural places. The patients usually decide where they would like to go and consult with the staff.

Medication

The use of psycho-active medication tends to be the norm in G22. Medication is prescribed by the registrar in consultation with the psychiatrist. Patients are consulted about their need for medication and their consent acquired. Commonly used medication at G22 include various types of anti-depressants, anxiolytic and low doses of anti-psychotic medication where appropriate.

(See appendix II for the ward G22 therapeutic programme.)

Staff groups

As part of the programme, weekly staff support groups with an outside facilitator occurs. All members of staff are expected to be present, while the nursing staff rotate so that there is always someone available for the patients. Issues of transference and counter-transference are

dealt with, as well as providing the space for staff to ventilate and to obtain support. Without this valuable venue, it is the writer's view that staff would burn-out and feelings would be displaced and projected inappropriately, which would have a detrimental effect on both patients and staff.

CONCLUSION

It is the writer's view that the ward G22 programme could be seen as an environment for ongoing personal learning, of a holistic kind, based on personal choice, decision and responsibility. It incorporates an ongoing multi-dimensional or eclectic framework for therapeutic intervention, as well as a facility for staff and student training.

CHAPTER FOUR

METHODOLOGY

General design of the study

The purpose of the study is to assess the efficacy of the therapeutic programme at Ward G22, Groote Schuur Hospital by focusing on the self-esteem of the patients upon admission to the unit and then again upon discharge from the unit.

In order to achieve this a quasi-experimental design will be employed, specifically using the one group pretest-posttest design.

Background to Single Case Design

According to Ruckdeschel and Farris (1981:413) the single case design has been advocated as the model most appropriate for evaluation of clinical practice. One needs to ask whether the small bits of intervention, in particular personal and social problems, involving particular social workers and particular clients and managed in particular ways, comes out roughly as predicted by those directly involved. Thus, within a specific unit where a small group of patients undergoes a particular treatment programme, the staff need to assess and evaluate the programme and its effectiveness.

The single case design has been considered to be a quasi-experimental design (Campbell and Stanley, 1963; De Vos, 1998) since it is premised on the logic of the experimental design, but lacks a control or comparison group and randomised assignment of subjects. It is therefore not a group comparison model, but a single subject design where each subject or case serves as his own control. The key element of the design is measurement, that is, identification of target

behaviour to be changed, establishing a baseline measurement of behaviour, specifying the intervention and then measuring the target behaviour a second time.

In this study the target behaviour would be self-esteem, which will be monitored on admission, thus forming the baseline measurement. The treatment programme would be the intervention, and self-esteem would be measured again on a scale at the end of the programme.

The origins of the single case design stems from behaviour modification. The use of the experimental investigation does offer practitioners the means of assessing their work without necessarily having to totally accept the theory of behaviour modification. The measurement of outcome and manipulation of intervention does, however, require some adoption of behavioural assumptions. The process by which the single case design found its way into social work practice appears as follows:

- there was a call for research into practice effectiveness;
- a survey of the research literature indicated that the existing literature models were not effective;
- there were practice and research strategies in other disciplines that were useful;
- group comparison research models yielded little in the way of results for practice;
- the N=1 (single subject design) seemed ideally suited to practice research;
- key issues in evaluation of practice was measurement (Ruckdeschel and Farris, 1981:415).

Therefore, it was concluded that the single case design is the design of choice for most research on practice effectiveness, based on the need for a more precise, more measurement oriented practice model.

Advantages of the method

Sheldon (1983:479) discussed the advantages of this design as follows:

- it would have both immediacy and believability for worker and client, whereas distantly arrived at findings do not;
- it would be detailed, offering personal feedback on individual performance rather than average "score" by either groups;
- replication could be quickly achieved.

The above would have benefits both within and between agencies, and could help to contribute toward the development of theory.

Limitations of the method

Criticisms of the single case design state that although it offers good correlational evidence of outcome, one cannot be sure of the many new variables introduced into a case by the actions of the researcher, a confounding variable, and that some problems improve regardless of what is done, the placebo effect, as one may have intervened at a fortuitous moment.
Single case designs do not improve the ability of the researcher to "generalise" beyond the individual case. Replication of the study would have to be done with other clients, other problems and in other settings. However, in this particular study the effectiveness of a specific programme in a local setting can provide an evaluation of the treatment process, it can be replicated, and it can possibly lead to theory development. In addition, the total population is being studied rather than a restricted sample and provides an optimum situation on which to base generalizations.

This method does not increase the ability of the researcher to make comparisons, however this is not the aim of the study. The study can be replicated within the ward and can offer a means of ongoing evaluation of treatment effectiveness.

Single case designs do not necessarily increase confidence in the validity of the observations, and may in fact impose concepts on the phenomenon that do not fit or correspond to the reality being studied. Ruckdeschel and Farris (1981:417) highlight that many measures and concepts used by researchers lack a relationship to the perspective of the actors/clients with the studied reality. A scale of measurement that leaves the client perspective out would pose an ethical problem.

They suggest that the researcher uses more qualitative research.

In the present study the Rosenberg Self-Esteem Scale (1965) is regarded as highly reliable with a correlation between 0.85 and 0.92 and also has predictive validity. The AB design, which makes a straight forward "before and after" comparison will be used. The list of data gathering methods include direct observation; participant observation; mechanical, electrical and other aids to observation, observation by mediators and self-observation. The latter will be used in the present study, that is, self-evaluation by means of a questionnaire/scale.

The success of self-recording depends on a basically cooperative client, a well organised scheme, a clear definition of what is to be counted, and whether the behaviours under review will make distortions likely. The patients who are admitted to the unit are motivated to enter the 9-12 week programme and are therefore usually cooperative. The scale is well organised and meets the other criteria as well.

Study population and sample

The population consists of a group of patients admitted to a therapeutic milieu, ward G22 at Groote Schuur Hospital from August 1995 until December 1995. It includes both males and females ranging from the ages of 15 to 47 years. The patients were all English Speaking, although their home language included English, Afrikaans and Xhosa.

The unit usually admits 14-16 patients for a 9-12 week period. Most patients complete the full programme, however some choose to leave earlier while others may negotiate an extra week or two. The shortest length of stay was 31 days while the longest was 102 days.

Sample

The sample in the present study consisted of all the patients admitted over a 4 month period, 23 patients, which is equal to the entire population for that period.

For the year 1995, 77 patients were admitted to the unit, however over the period August to December 1995 only 23 patients were admitted.

The patients are diagnosed according to the DSM-IV (Diagnostic and Statistical Manual of the American Psychiatric Association) criteria and included diagnoses of depression, anxiety disorders, eating disorders, post-traumatic stress disorder as well as personality disorders. The patients come from different social and cultural background, thus increasing the generalizability of the findings.

PROCEDURES FOR DATA COLLECTION

At a pre-admission interview each patient was assessed for suitability for the programme, his current level of functioning, mental status examination, ego resources for engaging in therapy and a diagnosis according to the DSM-1V multi-axial system.

Baseline data- pretest

On admission each patient was seen individually by the researcher and informed of the purpose of the study. The patients were informed that the researcher was interested in their subjective experience of self-esteem, and how their admission to ward G22 affected them. In order to investigate this, they would be assessed twice, once on admission and again upon discharge. Each patient was asked to complete the Rosenberg Self-Esteem Questionnaire. This served as the baseline data. This interview also established the legitimacy of the research and assured the respondents of confidentiality. It attempted to ensure cooperation, allow for a clarification of misunderstanding and ambiguity, while the questionnaire format would ensure uniformity of responses, enhance honesty and could be administered by any member of staff. The pretest also gave an indication of whether the hypothesis would be confirmed or rejected, as well as testing the feasibility of the study. Limitations included patients who decided to leave the programme prematurely, those who were uncooperative, as well as patients perceptions that their participation in the study was part of the ward programme and therefore they had no choice.

Intervention

The actual milieu programme consists of individual therapy, group therapy, evocative groups, life-skills training, anxiety management, relaxation techniques, individual and group crafts, family and/or couple therapy and where appropriate, behaviour modification for eating disorders. This formed the intervention and was the independent variable.

Posttest

Upon discharge each patient was interviewed by the researcher and asked to complete the Rosenberg Self-Esteem Questionnaire again, in order to measure the target behaviour. This was the dependent variable.

ETHICAL ISSUES

Since this research study took place within a hospital setting, it was necessary to obtain the permission of the Medical Superintendent and the Ethical Committee.

The Consultant Psychiatrist had already indicated that a study of this nature had not previously been undertaken and would be beneficial as a means of evaluating the treatment programme.

Another ethical issue concerned the patients or participants.

Their permission and co-operation was a necessary prerequisite while the aspect of confidentiality would be maintained by the anonymity of the questionnaire.

At the conclusion of the study feedback would be given to the ward concerning the results/findings of the study.

MEASUREMENT

The Rosenberg Self-Esteem Scale (1965) was administered to each patient on admission. the pretest. The therapeutic programme was the independent variable and participation in the programme was the treatment. Upon discharge each patient was administered the Rosenberg Self-Esteem Scale. the posttest.

The measure of self-esteem employed in this study is a ten-item Guttman scale, which is easy to administer. requiring respondants to check their answer to ten items. It can be completed in a few minutes. The Guttman Scale insures a unidimensional continuum by establishing a pattern to all other items on the scale. Respondants were asked to strongly agree, agree, disagree or strongly disagree with ten items (See appendix III for the Self Scale, Rosenberg 1965).

The items generally deal with a favourable or unfavourable attitude toward oneself. Low scores on the scale are an indication of a high level of self-esteem, which expresses the feeling that one is "good enough". Conversely, high scores on the scale are an indication of low self-esteem.

Strengths and weaknesses of measurement

Reliability

The scale is regarded as highly reliable (correlations ranging between 0,85 and 0,92) and evidence of convergent, discrimant and predictive validity have been reported (Rosenberg 1965:30; Tippett and Silber, 1965a,1965b). (Refer to appendix IV for the Self-Esteem Scale.) The reliability of the test has also been established within the South African context by Pretorius and Adam (1990), who administered the questionnaire successfully to 658 undergraduate students at the University of the Western Cape.

The estimate of internal consistencies (coefficient alpha) for the scale based on 659 subjects was 0,77 which can be considered adequate. The same interviewer will be administering the interviews and collecting the data. However with the posttest the subjects might over-cooperate or be non-cooperative. The posttest will occur 9-12 weeks later which might allow sufficient time for recall to be poor.

Validity

The scale was designed to be a unidimensional measure of self-esteem and a factor analysis with varimax rotation confirmed that one strong factor (eigen value is greater than 1) was sufficient to represent the statistical structure of the scale.

Non-inclusion of control groups

The setting up of a comparable group of patients to act as a control group in milieu therapy research is not feasible. According to Norman & Lowry (1995:17), this is due to the "field setting" of such studies.

Furthermore, the findings of Smith and Glass's (1977) study are relevant in this context. Some therapy is more effective than none at all in reducing patients' symptoms, suggesting that measurement of that symptom reduction is in itself important. While a control group would provide information on the efficacy of milieu therapy as opposed to other treatment modalities, this was not the aim of the current study, which was concerned primarily with measurement of change in patient self-esteem. If the focus had been to evaluate outcome in general, an attempt at inclusion of a control group may have been important. However, for the limited aims of the study, which was chiefly concerned with measurement of self-esteem using Rosenberg Self-Esteem Scale, this was not necessary.

There is an assumption of the uniformity of the therapeutic programme. This assumption of uniformity rests upon the following reasoning:

If the difference in effectiveness of varying therapeutic modalities is negligible (Smith and Glass, 1977), then it becomes possible to investigate change in milieu patients without necessarily attempting to specify the active ingredients of the milieu therapy programme, such as how various components of the programme address symptom reduction or self-esteem. It also becomes unnecessary to measure the efficacy of milieu treatment to other sort of therapy.

DATA ANALYSIS

Protocols were computer-scored.

Non-parametric tests or distribution free tests were used. These included the Wilcoxon Sign Rank test to determine whether the difference in the mean scores at the beginning and at the end of treatment were statistically significant. When comparing different groups, for example English vs non-English, males versus females, the Wilcoxon Rank Sum test was used.

The researcher used non-parametric tests as this was a very small sample size and therefore no assumption of a normal distribution could be made. She thus elected to use more robust and conservative tests of statistical significance.

The major advantage generally attributed to distribution-free tests is that they do not rely on any very seriously restrictive assumptions concerning the shape of the sampled population (Howell, 1989:298). The validity of the test is not affected by whether or not the distribution of the variable in the population is normal. Another advantage is that they are more sensitve to medians than to means, the simplicity of their calculations, and that they rank raw scores and operate on these ranks, and they offer a test of differences in central tendency that are not affected by one or few very extreme scores.

A major disadvantage generally attributed to distribution-free tests is their lower power relative to the corresponding parametric tests- that is, parametric tests are more likely to lead to a rejection of a false null hypothesis.

CHAPTER FIVE

RESULTS AND DISCUSSION

INTRODUCTION

The research findings of the current study need to be evaluated in the context of certain methodological considerations.

The small size limits the extent to which the study's findings may be generalised to milieu patient populations. However, closer consideration of certain results suggests trends which warrant further investigation. Such an approach views the scores in a clinical and social context, and will be used in this study to complement information yielded by statistical analysis of the data.

A type I error in significance testing refers to the risk of accepting a difference between scores as significance when it is not. This error becomes relevant when a study has a small sample size, such as that of the current study. However, since this study is a clinical one, these difficulties become unavoidable. The length of the G22 programme made extraction of a statistically respectable sample size difficult in the period available. The size of the sample, has also dramatically decreased the type of statistical investigation which may be performed on the data, and implies that caution should be taken when making inferences on the basis of the information yielded (Howell, 1989). In order to attempt to counteract the danger of making a type I error, the significance level may be lowered from the usual 5%, to 1%. However, this then causes the statistical evidence to tend towards making a type II error. This should be considered when evaluating the statistical procedures presented in this study.

RESULTS

Demographic Data:

(Refer to appendix V for correlations.)

Table I : *AGE*

VARIABLE	OBS	MEAN	ST. DEV	MIN	MAX
Age	23	26,09	8,12	15	47

There were 23 subjects, the mean age was 26.08 and standard deviation +8.12 years. The minimum age was 15 and the maximum was 47 years.

Table II : *GENDER*

GENDER	FREQUENCY	PERCENT	CUM
0	6	26.09	26.09
1	17	73.91	100
total	23	100.00	

note 0 = male

1 = female

TABLE 1

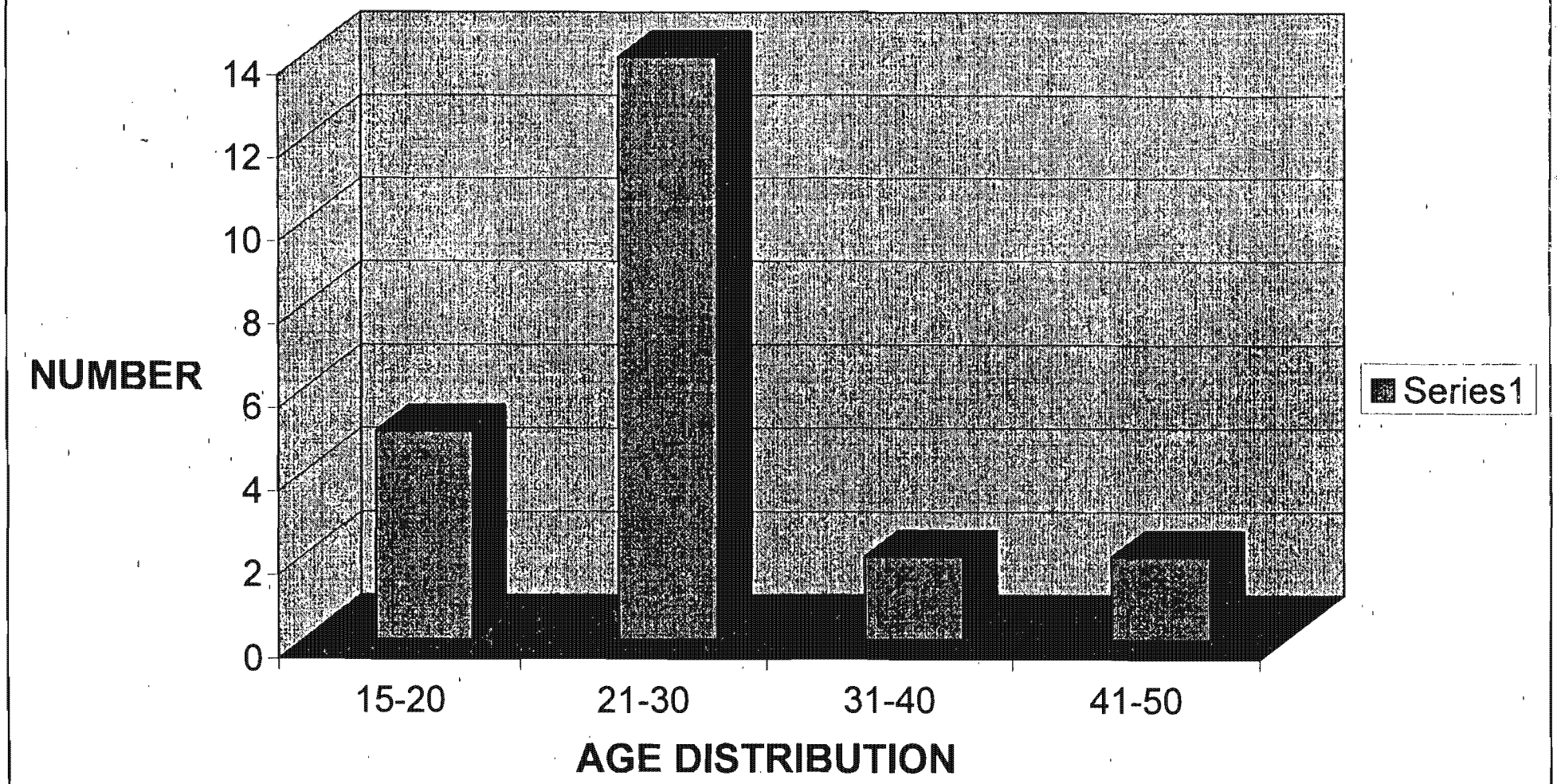
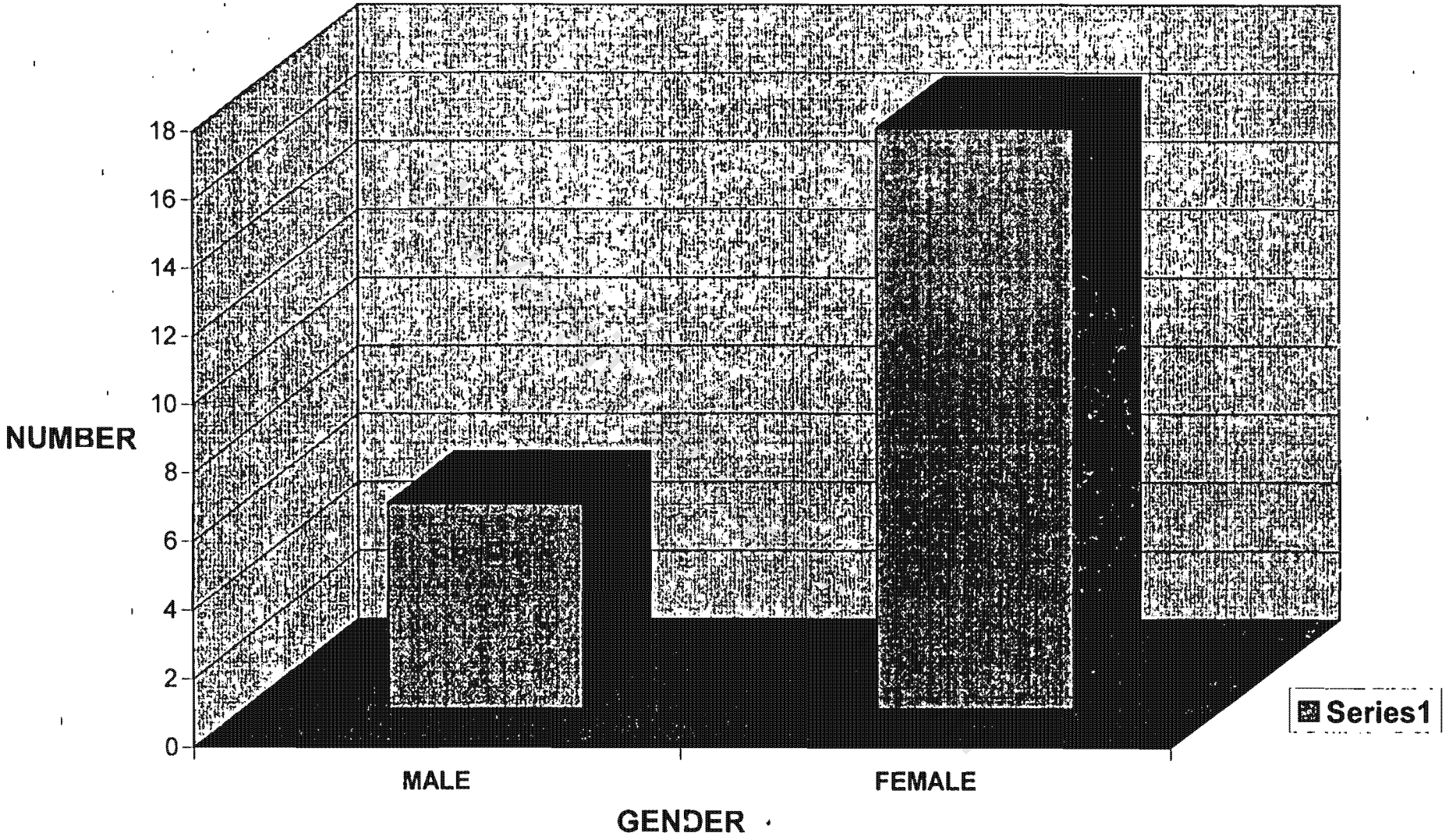

NUMBER
14
12
10
8
6
4
2
0
15-20
21-30
31-40
41-50
AGE DISTRIBUTION
Series1

TABLE 2



There were 23 subjects. 6 males who constituted 26.09% and 17 females which constituted 73.91%. The number of males is simply as a result of the pattern of admission to the unit at the time the data was collected.

Table III : *DAYS LENGTH OF STAY*

VARIABLE	OBS	MEAN	ST. DEV	MIN	MAX
days	23	73.30	20.04	31	102

There were 23 subjects and the average length of stay in G22 was 73.30 days, the standard deviation 20.04. The minimum length of stay was 31 days, and the maximum length of stay was 102 days.

Table IV : *LANGUAGE*

LANGUAGE	FREQUENCY	PERCENT	CUM
1	17	73.91	73.91
2	5	21.74	95.65
3	1	4.35	100.00
total	23	100.00	

note : 1 = English

2 = Afrikaans

3 = Xhosa

There were 23 subjects of whom 17 (73.91%) spoke English only, 5 (21.74%) spoke English and Afrikaans, and 3 (4.35) spoke English and Xhosa.

TABLE 3

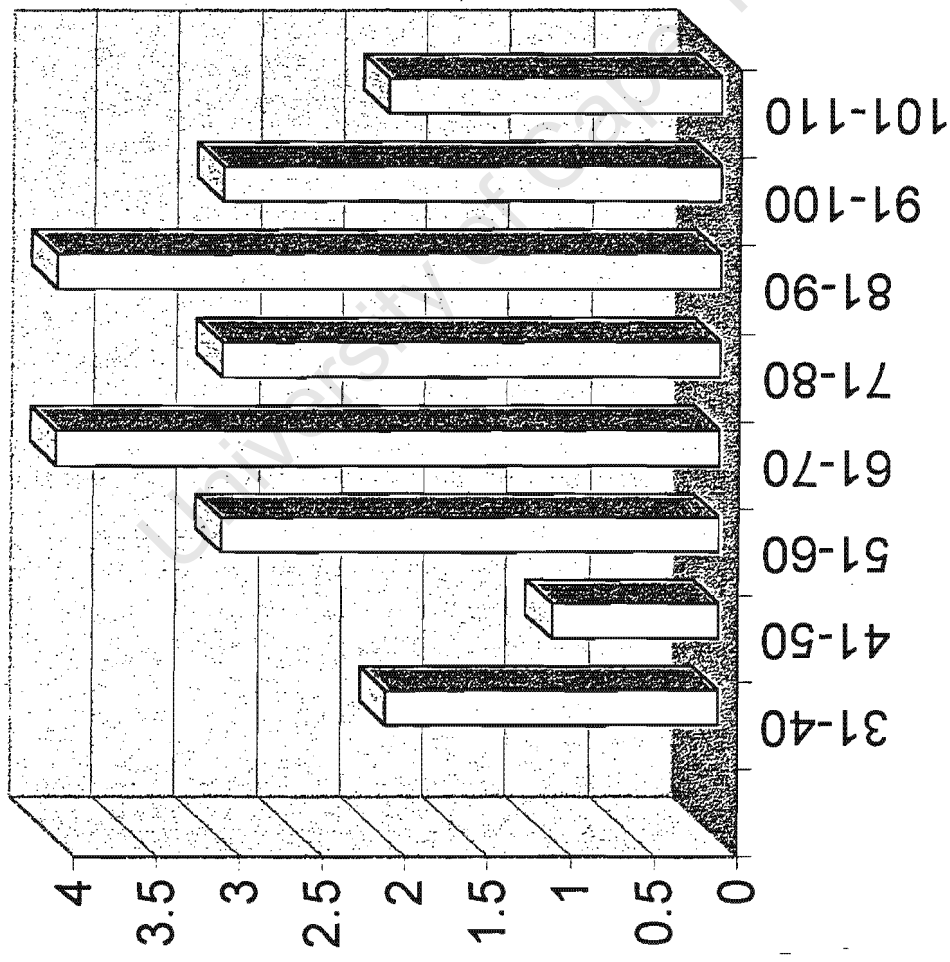
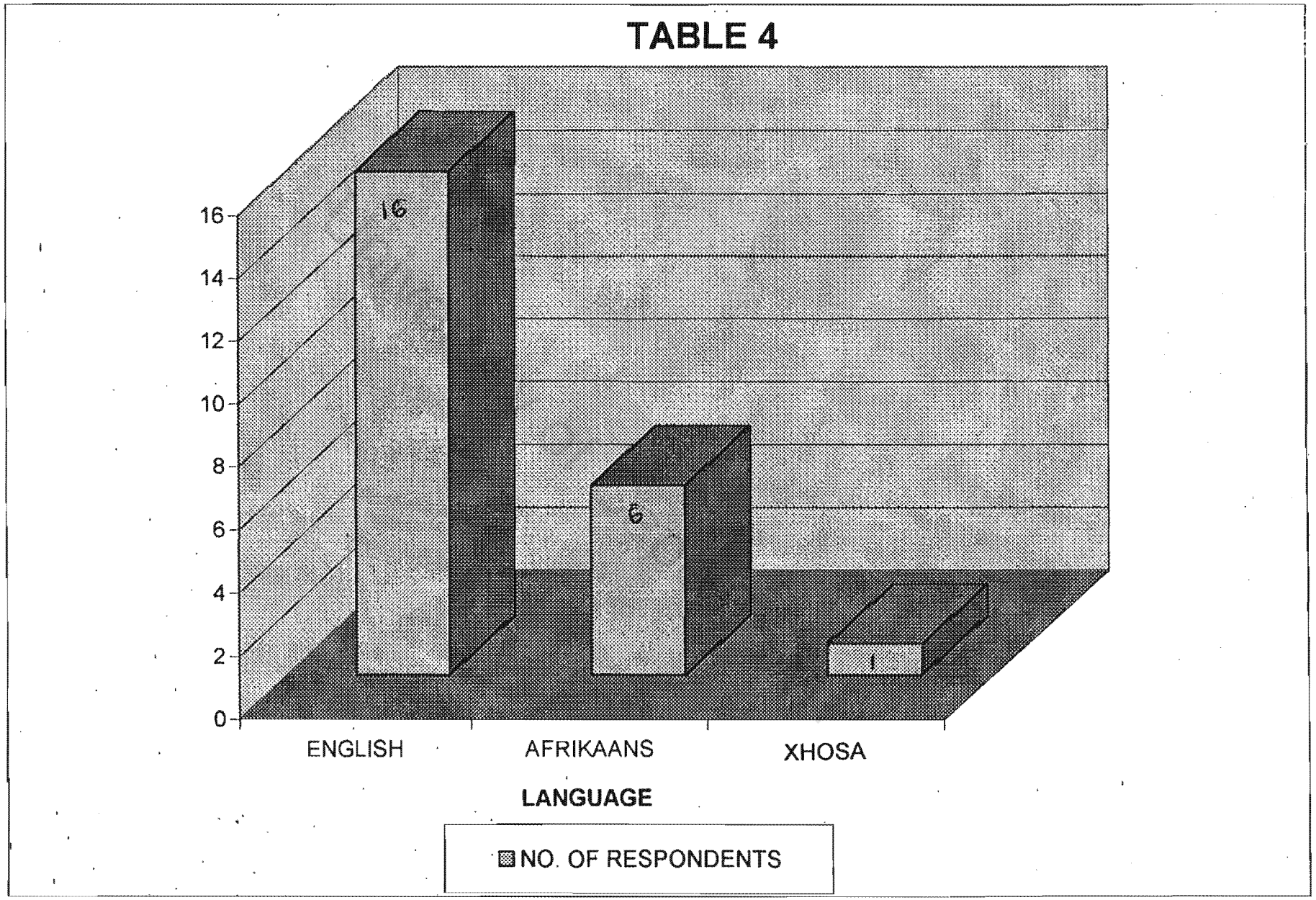


TABLE 4


16
14
12
10
8
6
4
2
0
16
6
1
ENGLISH
AFRIKAANS
XHOSA
LANGUAGE
NO. OF RESPONDENTS

Results from the Rosenberg Self-esteem questionnaire

Table 5 : *SELF-PRETEST*

VARIABLE	OBS	MEAN	ST. DEV	MIN	MAX
selfpretest	23	4.83	1.47	2	6

The pretest results for self-esteem consisted of 23 subjects, with a mean of 4.83 and standard deviation of 1.47. The minimum was 2 and the maximum was 6.

Table 6 : *SELF-POSTTEST*

VARIABLE	OBS	MEAN	ST. DEV	MIN	MAX
selfpostest	22	2.95	1.96	0	6

The posttest results for self-esteem consisted of 22 subjects, with a mean of 2.95 and standard deviation of 1.96. The minimum was 0 and the maximum was 6.

DISCUSSION

Pre-test and Post-test results

Wilcoxon Sign Ranked tests were performed to determine whether the difference in the mean score at the beginning and end of treatment were statistically significant. At the 5% level ($p < .05$) the posttest yielded significant results:

z stat = 3.65

prob > /z/ 0.003

From the above it is clear that there was a significant increase in the level of self-esteem from the pre- to the posttest.

Of the 23 subjects, one patient was excluded because he committed suicide and therefore did not complete the posttest. Only one patient's score remained the same (4.55%), that is, there was no difference between the pre- and posttest score (95.45%).

The results suggest a general trend towards improvement in self-esteem after treatment. This seems to support the goals of therapy or treatment as discussed by Mc Glasham & Miller (1982:381) when they state that "therapy should produce not only a person who possesses an intact sense of self, but also one who holds that self in substantial esteem.

The ward programme can be seen, according to Cooley (1950, in Rosenberg, 1965:12), as an event or transformation that alters one's perceived level of success and has the potential for altering one's overall sense of self esteem. Simultaneously the experience of the milieu programme in which patients and staff interact with each other in a specific way, could alter the individual's self-appraisal since the individual has to consider the reflected appraisal from others in their reactions to him. This, in turn, has a direct impact on one's global sense of self as interactional influences have a powerful bearing on self-evaluation.

Since the self is precipitated within a social matrix, the milieu appears to have provided a transitional space where individuals were able to re-experience and rephrase past experiences, learn new and alternate ways of dealing with problems of everyday living, as well as experiencing themselves in a social context where they were accepted and acknowledged,

thus also reinforcing their self-esteem. As noted by Josselson (1989:91), human beings are inexorably embedded in and with others, even in defining their selfhood.

Kohut's (1977, in Josselson, 1989:102) view of the importance of others for the definition of the self, where the selfobjects are seen as an aspect of another person that serves to maintain our sense of ourselves, is also relevant. The milieu programme can be seen as a social matrix which serves to enrich and stabilise the experience of the self. The experience of others in the milieu can serve as a validation of the self, and gives an indication of a sense of fit between self and social world, as well as a feeling of hope that the environment will be in tune to one much of the time.

Masterson (1985) similarly concluded that the "real self" grows as a function of adequate responsiveness from and in sharing with others. A prerequisite for admission to the milieu programme was that patients were motivated, that they would share on an emotional level and participate in the total milieu experience, which would enable the "self" to grow as a result of the mutual interaction that occurred. Stern (1985) also stressed the importance of interpersonal events such as emotional sharing as essential for the development of the self.

This also supports the findings of Petrie and Brook (1992:293-300) that people with a high level of meaning see their lives as having some purpose, and their life tasks as worthy investments in terms of energy and commitment, having the personal resources to cope with difficulties and demands they may encounter, and the degree to which the world is perceived as being understandable.

Results of correlations

Age and self-esteem

Wilcoxon Rank Sum tests were used to compare age, preself-esteem and postself-esteem. When correlating age and postself-esteem the results were -0.49, which is statistically significant at the 5% level ($p < .05$).

The results of age and preself-esteem were not statistically significant (0.1883).

These results indicate that the older the person was, the higher the level of self-esteem after completion of the programme.

The literature on adolescent development highlights that this is a period of metamorphosis from childhood into adulthood. The psychological task according to Erikson (1968), is to achieve a sense of identity vs identity diffusion, as well as a concomitant move away from dependence on parents to self sufficiency. This process is similar to the second separation-individuation phase of Blos (1967).

Adolescence is thus seen as the total reworking of the structure of the self, as the adolescent detaches and disengages from the objects of childhood, rebels against parents in search of autonomous will, becomes over-involved with peers to support an impoverished ego, and invokes rigid defenses to shore up a new fragile ego organisation (Josselson, 1989:92).

Counter-arguments against the above have been offered by Fischer (1986); Offer & Offer (1975), who found that the vast majority of adolescents maintain harmonious, loving relationships with parents throughout adolescence. They note that those adolescents who

show the highest self-esteem and most mature functioning, tend to have the most interrelationship with their parents, that peers take on added importance but do not supercede the influence of parents in important decision-making, and they conclude that attachment to parents continue unabated throughout adolescence and into adulthood.

The literature seems to support the findings of this study, in that the adolescents who were admitted to the unit, experienced relationship problems, had feelings of poor self-esteem and problems in daily living, which precipitated admission to the unit in the first instance. The milieu programme can thus be seen as an opportunity for growth.

The development of self-esteem can be viewed as an analogy to rapprochement (Mahler et al, 1975), where concern with autonomy is blended in the context of relatedness. These adolescents were able to explore new ideas and ways of being within the therapeutic community, to receive recognition by fellow patients (peers) and staff (authority-figures) as the latter accepted these new aspects of the patient, while still maintaining a relationship\connection to the patient. Thus, the adolescent was able to realise that both individuality and connectedness were necessary to their development.

Adolescence is a long period of negotiation between an adolescent and the important inner and outer objects, to find a balance that is mutually tolerable. It implies continued, renewed, often strengthened but revised connectedness. A more clearly delineated sense of self makes new forms of relatedness possible.

The self is experienced as an object of others attachment. Both our evaluation and our experiences of our self is rooted in what we mean to others (Josselson, 1977:102). The self

can grow as a function of adequate responsiveness and sharing with others, which the milieu experience would have provided.

Gender and self-esteem

When comparing gender with self-esteem, the Wilcoxon Rank Sum test was used. The results of gender and preself-esteem are:

z stat = -0.74

prob > /z/ 0.46

This is not statistically significant at the 5% level.

The results of gender and postself-esteem are:

z stat = -1.76

prob > /z/ 0.0779

This is not statistically significant at the 5% level.

These results indicate that gender did not significantly influence the pre- and post- self-esteem results. Self-esteem improved irrespective of the gender of the patients.

Results of Length of Stay (Days) and Self-Esteem

When comparing length of stay and preself-esteem the results were 0.1674, which is not statistically significant at the 5% level.

When comparing length of stay and post self-esteem, the result was 0.0066, which is not significant at the 5% level.

These results indicate that the length of stay did not significantly influence the level of self-esteem before and after the programme. Self-esteem improved irrespective of the length of stay in the unit.

Language and Self-Esteem

Wilcoxon Rank Sum tests for comparing language and post self-esteem were done. At the 5% level ($p < .05$) the

results were:

z stat = -1.81

prob > /z/ 0.0709

The results indicate that language did not significantly influence the level of self-esteem.

Age and Gender

When comparing age and gender, Wilcoxon Rank Sum tests were done. At the 5% level ($p < .05$) the results were:

z stat = 1.44

prob . /z/ 0.512

These results are not statistically significant, and mean that gender did not significantly influence the results.

EVALUATION OF THE STUDY

Twenty two of the twenty three patients showed an improvement in their self-esteem score. This has implications for the changes in clinical symptomatology such as depression. Beck (1967. in Rosenberg 1965) indicated that low self-esteem is one of the distinguishing features of depression, and hopelessness is an important predictor of suicidal behaviour and ideation. Self-esteem is therefore relevant in the development of emotional disturbance while a high level of self-esteem or acceptance is an important component of mental health.

It would have been useful to have included a depressive scale as part of the questionnaire. This might have confirmed the link between depression and low self-esteem of the patients in the current study, especially in view of the one patient who committed suicide. Nevertheless, the self-esteem score for the patient who committed suicide indicated that he was extremely depressed and scored the highest points, which is indicative of a low self-esteem.

It is difficult to make predictions of treatment outcome without doing a follow-up of post hospital adjustment, which according to Ellsworth et al (1979) is the most adequate measure of treatment outcome. Thus, the limitations of the study become apparent. It would have been appropriate to have a follow-up study with this group of patients in the months after discharge, in order to establish to what extent their measured improvement was maintained. Subsequent to this study the ward programme has started offering a support group for a period of six weeks after discharge.

Furthermore, the findings of Ellsworth et al (1979) with reference to outcome measures. suggest that the pre- and post ratings used to assess change in the current study could certainly be supplemented, or even replaced by the measure of "judged improvement" as perceived by patients, staff and perhaps family members.

There is insufficient consideration of the many factors which may intervene during, and affect patient outcome, after a three month hospitalization. These factors include unspecified characteristics brought to the treatment situation by patients, factors related to the milieu itself. such as staff characteristics, and staff and inter-patient dynamics (Ellsworth et al, 1979).

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

In discussing the results of this study, it has been suggested that there is a need for further research in G22, based upon the current study. The following conclusions should be evaluated in the light of this recommendation:

The findings of this study confirm that the self-esteem of a group of patients improves as a result of a 9-12 week admission to a therapeutic milieu programme. Since self-esteem has been correlated to emotional disturbance (Rosenberg, 1965), an improvement in the level of self-esteem could have a corresponding decrease in levels of depression and anxiety. The bulk of the improvement then, would be in the area of clinical symptom variables. Further research to assess the levels of depression and anxiety, and to correlate it to self-esteem, would be necessary.

The findings also indicate that the older the patients were, the higher their level of self-esteem after completion of the milieu programme. This is in keeping with the findings of Rosenberg (1979) who found that the self-concept is particularly volatile during adolescence. Further research needs to be done to assess whether adolescents should perhaps not be admitted to the unit, but should be referred to the adolescent unit where they would be more appropriately placed with peers.

The findings further indicate that self-esteem improves irrespective of the gender or the language spoken by these patients. Both males and females improved on their self-esteem

score after completion of the programme, whether their home language was English, Afrikaans or Xhosa.

The findings of this study indicates that irrespective of the length of stay in the unit, the patients improved their level of self-esteem. This supports the research findings of Smith & Glass (1977) that some therapy is better than none at all, despite the short length of stay in the unit.

As a result of the small sample size of this study, it would be necessary to do further research to assess whether change is maintained in post-hospital adjustment, whether the level of self-esteem is maintained, as well as the general improvement in interpersonal functioning.

Finally, it is recommended that further research which pays attention to the role of the treatment context be undertaken in G22. Clinicians should give cognisance to the importance of self-esteem as an indicator of mental health, and how intervention can impact substantially on the experience of self in relation to others.

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Admission procedure

Referrals by private psychologists and psychiatrists, social agencies, medical practitioners and provincial hospitals are accepted. Telephonic, followed by written, referrals are requested. The patient and family are seen at an initial panel assessment. Suitable candidates are then placed on a waiting list for admission.

The team

The permanent staff consists of a psychiatrist, clinical psychologist, social worker, occupational therapist, dietitian and nursing staff with psychiatric training.

Trainees rotating through the unit include psychiatric registrars and intern clinical psychologists. Medical, occupational therapy, dietetic and nursing students pass through the unit.

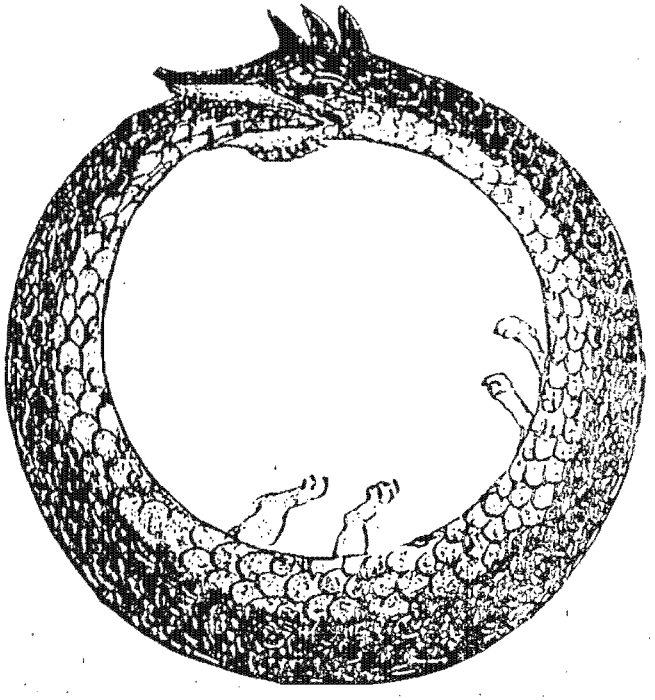
Discharge and follow-up

Wherever possible patients are returned to the original referral source with an in-patient summary. Other patients are referred to out-patients, individual therapists and/or family therapy. Patients with eating disorders are referred to the eating disorders clinic and group in R11.

Groote Schuur Hospital

Ward G22

Psychiatric In-patient Unit



Telephone: 404-2155

APPENDIX 1

WARD G22 PROGRAMME

(*) PATIENTS MAY BE EXCUSED FOR INDIVIDUAL / FAMILY THERAPY / STUDENT CLERKING

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
07h00	NIGHT HANDOVER	NIGHT HANDOVER	NIGHT HANDOVER	NIGHT HANDOVER	NIGHT HANDOVER
07h30	W/END FEEDBACK/MEDS	FEELWALL/MEDS	FEELWALL/MEDS	FEELWALL/MEDS	FEELWALL/MEDS
07h45	BREAKFAST TEAM HANDOVER	BREAKFAST TEAM HANDOVER	BREAKFAST TEAM HANDOVER	BREAKFAST TEAM HANDOVER	BREAKFAST TEAM HANDOVER
08h30	GROUP	LIFE SKILLS	GROUP	GROUP CRAFTS	GROUP
09h30	GROUP HANDOVER		GROUP HANDOVER	STAFF WARD ROUND	GROUP HANDOVER
10h00	TEA	TEA	TEA	TEA	TEA
10h30	PATIENT ADMIN & SOCIAL CLUB	ANXIETY MANAGEMENT	LIFE SKILLS	EVOCATIVE TECHNIQUES	RELAXATION
11h30	STAFF WARD ROUND	WEIGHT MEETING	STAFF SUPPORT GROUP		11h00 COMMUNITY MEETING
12h00	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
12h30	MEDS	MEDS	MEDS	MEDS	WEEKEND MEDS
13h00	*LEISURE SKILLS	GROWTH GAMES VALUES/EDUCATION	COMMUNITY MEETING	GOALS & TASKS	
14h00	INDIVIDUAL THERAPY	14h30 *WALK	14h30 *WALK	14h30 *WALK	INDIVIDUAL THERAPY
15h00	TEA	TEA	TEA	TEA	
15h30	INDIVIDUAL THERAPY	INDIVIDUAL THERAPY	INDIVIDUAL THERAPY	INDIVIDUAL THERAPY	

PPENDIX 3

SELF SCALE

Indicate the extent to which you agree with the following scale

SA = strongly agree

A = agree

D = disagree

SD = strongly disagree

Make an X over the appropriate letter.

1. I feel that I am a person of worth, at least on an equal basis with others	SA	A	D	SD
2. I feel that I have a number of good qualities	SA	A	D	SD
*3. All in all, I am inclined to feel that I am a failure	SA	A	D	SD
4. I am able to do things as well as most other people	SA	A	D	SD
*5. I feel that I do not have much to be proud of	SA	A	D	SD
6. I take a positive attitude toward myself	SA	A	D	SD
7. On the whole I am satisfied with myself	SA	A	D	SD
*8. I wish I could have more respect for myself	SA	A	D	SD
*9. I certainly feel useless at times	SA	A	D	SD
*10. At times I think I am no good at all	SA	A	D	SD

SCORING

Items marked with an * : SA = 4

A = 3

D = 2

SD = 1

Items not marked with an * : SA = 1

A = 2

D = 3

SD = 4

Rosenberg, H.,1965.

Correlation between self-esteem and subscales of the HIF

	Self-esteem
HIF	
Anxiety	-0.33*
Aggression	-0.15*
Depression	-0.40*
Global	-0.37*

* = $p < 0.05$

The correlations presented in the above table are all significant and all are in the expected direction, which serves as evidence for convergent validity.

Comments The scale is a brief but reliable and valid measure of the self-acceptance aspect of self-esteem. Although designed for use with high school students it seems equally applicable to other age groups as demonstrated by the present findings.

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SELF SCALE

Indicate the extent to which you agree with the following ten statements by using the following scale:

SA = strongly agree
A = agree
D = disagree
SD = strongly disagree

Make an X over the appropriate letter.

1.	I feel that I am a person of worth, at least on an equal basis with others	SA	A	D	SD
2.	I feel that I have a number of good qualities	SA	A	D	SD
*3.	All in all, I am inclined to feel that I am a failure	SA	A	D	SD
4.	I am able to do things as well as most other people	SA	A	D	SD
*5.	I feel that I do not have much to be proud of	SA	A	D	SD
6.	I take a positive attitude toward myself	SA	A	D	SD
7.	On the whole I am satisfied with myself	SA	A	D	SD
*8.	I wish I could have more respect for myself	SA	A	D	SD
*9.	I certainly feel useless at times	SA	A	D	SD
*10.	At times I think I am nogood at all	SA	A	D	SD

Scoring:

Items marked with an *:	SA = 4
	A = 3
	D = 2
	SD = 1
Items not marked with an *:	SA = 1
	A = 2
	D = 3
	SD = 4

PENDIX 5

SUBJECT NUMBER	AGE	GENDER MALE = 0 FEMALE = 1	LENGTH OF STAY - DAYS	LANUAGE ENGLISH = 1 AFRIKAANS = 2 XHOSA = 3
1	47	1	64	1
2	19	0	59	1
3	24	1	88	1
4	43	0	67	1
5	37	0	66	2
6	27	1	31	1
7	17	1	95	1
8	25	1	72	2
9	15	1	94	2
10	19	1	102	1
11	21	1	86	1
12	23	1	52	1
13	24	1	80	1
14	22	1	101	3
15	23	0	89	2
16	29	0	73	2
17	24	1	38	1
18	29	0	80	1
19	27	1	66	1
20	26	1	52	1
21	22	1	49	1
22	38	1	87	2
23	19	1	95	1